Massachusetts Commission for the Deaf and Hard of Hearing
Interpreter Request Fax Form

(Items marked with a diamond (◆) REQUIRED for form to be complete)

incomplete forms cannot be processed

Please fax to (617) 740-1880

◆ Today's Date:	◆ Your Name:
◆ Your Phone #: **Ext.**	◆ Your Fax #:
◆ Your Agency:	
◆ Date(s) of Assignment:	
◆ Beginning Time of Assignment:	◆ End Time of Assignment:
◆ Location/Address of Assignment: (include bldg., floor, and room #)	
◆ On-site Contact Person:	◆ Phone # On-site: **Ext.**
◆ Description of Situation/Nature of Assignment:	
◆ Names of Deaf or Hard of Hearing Person(s):	
Communication Preference, if known (ASL, Signed English, tactile, CDI, etc):	
Requested Interpreters (unless otherwise specified by requestor, Referral Service will also check with other qualified Interpreters if requested Interpreters are unavailable):	
Total # of Participants	Other Agencies Involved:

Billing Information
(Request will NOT be processed without billing information)

◆ Contact Person:	◆ Phone Number: **Ext.**	
◆ Agency Name:		
◆ Street Address:		
◆ City:	◆ State:	◆ Zip:

I have read MCDHH Interpreter/CART Referral Service Policies and Procedures, and, by signing my name below, a)I certify that all information is correct and b)I agree to adhere to all terms and conditions.

Signature Date

Print Name **Title**

OFFICE USE ONLY

Area:	Job #:
Received By:	Entered By: